Working With Your State Legislature

A Guide for Substance Use Disorder and Mental Health Stakeholders

Introduction

Your State legislature plays an important role in shaping how the Affordable Care Act (ACA) will look "on the ground." In most States, the legislature has a part in:

- Developing and implementing the health insurance marketplace;
- Determining whether or not to move forward with expanding the Medicaid program;
- Ensuring your State can enforce the requirements of the ACA; and
- Deciding whether or not to pursue strategies to better integrate mental, substance use, and physical health care.

This Guide offers specific strategies to help you effectively collaborate with your State legislature to raise awareness of issues impacting persons with substance use or mental health needs, to stay informed about legislative developments in your State, and to design successful strategies for mental health and substance use disorder (MH and SUD) prevention, treatment, rehabilitation and recovery.

State Legislature Roles and Responsibilities

State legislatures pass, amend, and repeal State laws the same way that the U.S. Congress enacts federal laws. Legislators create State budgets, appropriate money to fund activities in that budget, and raise funds by levying taxes. They also pass laws that govern health policy, including policies related to mental health and substance use disorders. States have the same system of checks and balances that exists at the federal level –with a legislative body, State executive officer (governor), and State judiciary.

Each State's legislative session schedule is different. When they are in session, they consider bills and proposals introduced by individual legislators or submitted by the governor. Legislatures consider and approve a State's operating and capital budgets.

The Role of Legislative Staff

Since State legislators come and go, particularly in States with term limits, long-serving legislative staff are important resources. In addition to setting agendas for committee meetings and doing research on issues, they stay on top of the performance of State programs, including mental and substance use disorder policies and programs. In most cases, legislators rely heavily on their staff to keep them informed about the issues, because of their knowledge and institutional memory. By educating and informing staff members, you are influencing and informing legislators.

One important job of legislative staff is to "drill down on issues," becoming as expert as possible and sharing that information with legislators. Staff also serve as gatekeepers for legislators, letting them

know what's important, which data are most useful and the various interests and positions on issues. They are also a great resource in understanding how best to communicate information and resources to legislators. In some States, staff members have worked on mental health and substance use disorder policy issues for decades, so they are the experts and the "go to" people for legislators. Staff members manage committee hearings and other meetings and are a great resource for finding out about activities that you should know about and participate in.

To find out who the staff members in your State are who are most interested or involved in mental health and substance use disorder issues, find out what committees there are. Your State legislature may have a web site that lists this information. For example, health, judiciary, insurance, appropriations and budget committees will probably have staff interested in these issues. In many States, individual legislators also have personal staff. These people may also be helpful in developing opportunities for collaboration and advocacy.

Communicating Effectively with your Elected Officials

- **Identify key stakeholders to engage and work with in coalition**
  Effective collaborations involve a broad range of partners, and it is more powerful when you work together, using a common message. Because legislators represent their constituents (and need to get re-elected), engaging with a diverse group of stakeholders, including allied health, disability, social welfare and criminal justice organizations, that speak with one voice will strengthen the organized constituency advocating on substance use and mental health issues.

- **Identify effective legislators as partners**
  It is important to find champions who are in the legislature. Do your homework as you're looking to identify your champion. Learn about their background, expertise, and interests so that you can tailor your messages effectively. For example, in many States there are legislators who work in the field – as treatment providers or counselors or health care professionals. In some States, champions are legislators who are in recovery or who have family members in recovery or struggling with addiction and/or mental illness. Legislators whose districts have been hard hit by drug overdoses, suicides, or other problems are also potential champions.

- **Get to the point and prioritize your ideas when you meet**
  Keep in mind that legislators have a lot on their plates and that they likely will have limited time to devote to your interests. That's why it's important to identify a few, specific goals before you meet with her or him. One tip is to prepare a concise goal statement and talking points to help provide focus and direction to your meeting. Remember, you're building a relationship and you don't want to overwhelm them. A rule of thumb is to pick no more than three ideas and present them well with some specific "asks" and develop a concrete plan for action going forward with your legislator.

- **Create user-friendly materials**
  The principles of short, concise and readable apply to all written materials. Legislators are unlikely to read a 100-page report, so a 1 or 2 page executive summary is essential. List bullet points of important findings. Use the "USA Today" format (color, graphics, visually appealing, etc.) to make your information as easy to read as possible.

- **Think about where you're going to be speaking and prepare**
  Whether you're invited to speak at a meeting, give testimony at a hearing, or attend a meeting, be sure to prepare for the format. Ask about how long you can speak, who the other speakers will be, if there's going to be AV equipment (i.e., PPT projector and screen), the number of handouts you need to bring, and whether it is open to public.

- **Highlight cost-effective approaches**
  When it comes to talking about substance use and mental health disorders, there is significant data on the problems and ample effectiveness data, but little or no cost-effectiveness data. Cost-effectiveness is important, especially in these tight budgetary times. Because legislators must balance a broad range of interests and priorities to create a State's budget, it is very important to show cost-effectiveness, cost offsets, and cost savings when possible.

- **Make your data personal by using real life stories**
  Legislators, like everyone, respond to real-life examples. They bring data to life and personalize why it's important to act. Make sure to use personalized stories that help to illustrate the real-world implications of abstract policies and connect issues directly to the constituents whom legislators represent.

- **Follow-through is very important**
  Whether you're giving a talk, attending a meeting, or run into an elected official in your community and they listen to what you have to say, follow up with a thank you and build a relationship for the future. You can send follow-up information, invite them to an event and keep in touch with legislative staff about next steps and to keep the ball rolling.

Summary

Your State legislators can be important allies in helping to make sure that people with substance use disorders and mental illness can get the help and support they need to recover and live full lives in the community. Citizens, organized constituency groups, businesses and other special interest organizations that understand the State legislative process use it to advance policies that support their goals.

For More Information

The website of the **National Conference of State Legislatures (NCSL)** includes information about ACA implementation activities: http://www.ncsl.org

The website of the **National Academy for State Health Policy (NASHP)** includes information about ACA implementation activities: http://www.nashp.org/

NASHP operates the **State Refor(u)m**, which is an online network for health reform implementation: http://www.statereforum.org/

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** website details information about how health reform affects people living with mental health and substance use disorders. It also includes an archive of health-reform related webinars: http://www.samhsa.gov/healthReform/

The **Kaiser State Health Facts** website includes links to State specific facts on health insurance, managed care, and other health information: http://Statehealthfacts.org/

Healthcare.gov is a Federal government website dedicated to health reform issues managed by the U.S. Department of Health and Human Services. Site includes information about key features of the ACA, an interactive timeline of implementation dates for key provisions, and tools to help people locate insurance: http://www.healthcare.gov/

Ensuring Health Plans Meet ACA Standards for Access to Needed Mental Health and Substance Use Disorder Services

A Toolkit for State-Level Advocates

The health insurance coverage expansion provisions of the Affordable Care Act (ACA) will begin to go into effect in January, with enrollment beginning in October. As private health insurance coverage is expanded, seventeen states will operate their own health insurance exchanges and will therefore be responsible for certifying the Qualified Health Plans (QHPs) that will operate in these exchanges. In addition, seven partnership exchanges will have ongoing plan management responsibilities, as will a handful of other federally run exchanges. Health plans seeking to become QHPs on the exchange must meet a number of consumer-protective requirements in federal and state law, and states have a considerable amount of flexibility to define criteria required for certification. Non-grandfathered plans sold to individuals and small businesses outside of exchanges also must comply with a number of new consumer protection standards. **Strong advocacy in the states is needed this summer and fall to ensure that enrollees in private plans will be able to appropriately access needed mental health (MH) and substance use disorder (SUD) services, as envisioned by the Affordable Care Act.**

To ensure that there is good access to MH and SUD care in the commercial market, between now and the end of 2013 it is important that affiliates and partners of national Coalition for Whole Health member organizations advocate with insurance commissioners, exchange board members, and other key policy-makers to ensure enrollees in exchange plans will be able to appropriately access needed MH and SUD services.

The purpose of this toolkit is to provide advocates with the materials they need to advocate with state officials responsible for health plan certifications, licensing, and oversight. The materials will focus on three main plan certification priorities of the Coalition:

1. Essential health benefits, including the use of any allowed flexibility to improve coverage for MH/SUD services rather than potentially undermine the continuum of care;
2. MH/SUD parity and meeting the other consumer protection requirements of federal law; and
3. Network adequacy requirements, including the requirement that provider networks be sufficient to allow access to MH/SUD services without unreasonable delay.

As states begin to certify plans as QHPs and oversee plans generally for ACA compliance, it is important for advocates representing individuals with MH/SUD to effectively work to ensure appropriate coverage for these illnesses. Although in most states detailed plan information is not yet publicly available, work this summer to educate insurance commissioners and other key state policy-makers about how best to ensure good access to MH and SUD care is extremely important.

This toolkit is intended to provide state advocates with the information they need to advocate for the three main priorities the Coalition has identified. This toolkit also includes

guides for MH/SUD stakeholders on working with insurance commissioners and state legislators. In addition, it is important for advocates to familiarize themselves with any state-specific benefit mandates, parity laws, network adequacy requirements, or other MH/SUD related requirements that QHPs operating in their state must meet.

Later this year, specific plan details will be made available in all states, including states with federally-facilitated exchanges. Over the coming months, the Coalition will develop additional materials to help state-level advocates to evaluate plans for MH/SUD coverage, identify instances and patterns of noncompliance with parity and other protections, and report potential violations.

Additional resources are available at www.coalitionforwholehealth.org. Please feel free to contact Dan Belnap (dbelnap@lac.org) or Gabrielle de la Gueronniere (gdelagueronniere@lac-dc.org) at Legal Action Center with any questions.

Part I: MH and SUD Benefit Recommendations

Background: Before an insurance company can sell products on the exchange it must be certified as a Qualified Health Plan issuer, and to be certified it must meet a number of requirements under federal law. This includes the requirement that its proposed products for the exchange provide coverage for the ten categories of Essential Health Benefits (EHB) in the ACA, including mental health and substance use disorder benefits. These requirements also apply to non-grandfathered health plans sold to individuals and small businesses outside of exchanges. The EHB requirements vary by state and are based on a state-specific "benchmark plan." However, the federal regulations governing the EHB requirements allow states and health plans some flexibility to deviate from the coverage offered by the benchmark plan, and states should use the available flexibility to ensure plans provide quality coverage of all medically necessary services across the continuum of care in each of the EHB categories, including the MH/SUD category.

Messages for state policy-makers: As regulators review health plan proposals, it is extremely important that they ensure adequate coverage of complex illnesses, including MH/SUD, and refuse to certify plans that fall short. To be certified, health plans must comply with federal and state laws and be adequately comprehensive to meet the full array of needs of all plan enrollees.

Adequate MH and SUD coverage addresses the full continuum of care for these illnesses, covers services to meet plan enrollees' multiple needs, and recognizes that no single treatment for mental illness and substance use disorders is effective for all individuals. As states move forward to certify health plans for participation on the exchanges and to assess general compliance with ACA requirements, each product's coverage of mental health and substance use disorder services should include, at a minimum, the following Coalition for Whole Health recommended benefits[1] to adequately address MH/SUD:

- Outpatient treatment, such as assessment, treatment planning, laboratory services, individual, group, and family evidence-based psychotherapy services, and appropriate medication prescribing and monitoring. Outpatient treatment should also cover screenings, referral, and ambulatory detoxification.
- Inpatient hospital services, including detoxification and psychiatric stabilization services.
- Intensive outpatient services, including partial hospitalization services.

[1] The Coalition for Whole Health list of recommended mental health and substance use disorder services follows the benefits outlined in the Coalition's "EHB Consensus Principles and Service Recommendations," a set of benefit recommendations released by the Coalition and endorsed by over 150 national, state, and local organizations in the MH/SUD fields. These recommendations are similar to other MH/SUD benefit recommendations that have been developed, including those outlined in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) "Description of a Good and Modern Addictions and Mental Health Service System." They are based on a review of which MH/SUD services have typically been offered through employer plans and on evidence-based practices that are effective and necessary to help people get well and stay healthy.

- Intensive home-based treatment, including services for children and adults with serious mental illness and/or substance use disorders such as counseling, behavior management, and medication management.
- Crisis services, including emergency room crisis intervention, stabilization, and mobile crisis services.
- Residential substance use disorder treatment, including all services related to sub-acute residential substance use disorder treatment that corresponds to the American Society of Addiction Medicine's care level III.
- Prescription drug coverage of all appropriate medications for mental health and substance use disorders.
- Psychiatric rehabilitation skills training and related services to address functional impairments, and rehabilitative services designed to avoid institutional placement for children and adults with severe mental illness.
- Recovery support services, including peer support and coaching.
- Prevention, early identification, and treatment services, including age appropriate outpatient, inpatient, and home-based pediatric mental health and substance use disorder prevention services, screenings, treatment, recovery, and rehabilitative services.
- Additional preventive and wellness services that include home visiting programs, consumer and family education services related to healthy lifestyles and substance use prevention, other prevention services required by the ACA, and education and skills training.
- Comprehensive care management, including intensive case management for persons with severe mental illness and substance use disorders.
- Care coordination and health promotion, including care coordination services for children, adults, and elderly persons with mental illness and substance use disorders, and appropriate referral to community and social support services.

In addition, as regulators work to certify plans and confirm plan compliance generally with EHB requirements, it is important to pay special attention to additional protections related to MH/SUD that were included in the final EHB regulations. Specifically:

- The final rule made clear that states must supplement the EHB as needed to meet the requirements of parity and clarifies that states will not have to defray the cost associated with bringing the EHB into compliance with parity, since parity is a requirement of individual and small group health plans under the Affordable Care Act.
- The rule also provides special rules for prescription drugs, requiring a plan to cover at least the greater of 1) one drug in every category and class, or 2) the same number of drugs in each category and class as the EHB-benchmark plan, and requires a plan offering the EHB to have procedures in place to ensure that enrollees have access to clinically appropriate drugs that are prescribed by a provider but not included on the plan's drug list. The regulations also state that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding the EHB.

Regulators should carefully review proposals to ensure that the plans meet these prescription drug requirements for MH/SUD and the requirements related to the EHB, parity, and other protections discussed in Part II of this toolkit.

Part II: Ensuring Compliance with Parity and the other Consumer-Protective Requirements of the ACA

Background: The ACA requires that each Qualified Health Plan's coverage, along with coverage in individual and small group plans sold outside of exchanges, complies with a number of consumer-protective parity and non-discrimination provisions. Under the ACA, the Essential Health Benefits package—the minimum benefits that must be provided by all QHPs—must meet these protections. In addition, a QHP's policies and practices beyond the EHB, such as benefit management and treatment limitations, must meet the consumer protection requirements in the law. As regulators review health plans for certification to participate on the exchange and for ACA compliance generally, they must pay detailed attention to the proposals to ensure that all protections in the law are being met.

Messages for state policy-makers: Under the ACA, individual and small group plans must comply with a number of specific consumer protective requirements for benefits, parity, non-discrimination, typicality of coverage, and EHB categorical balance. Following the subheadings are short summaries of what the law requires and a discussion of what would constitute a violation.

The product seeking certification must provide coverage for MH and SUD benefits, as required by the ACA

The ACA requires that all qualified health plans and non-grandfathered individual and small group plans sold outside of exchanges provide ten categories of essential health benefits, including benefits for mental health and substance use disorder services. The Department of Health and Human Services has allowed states the flexibility to influence their own EHB by benchmarking to existing health coverage available in the state, and provided a framework for adding in benefits for EHB categories that may be missing in the benchmark.

The state's EHB benchmark is a starting point for defining the benefits that a qualified health plan will offer. Within the regulatory framework and as allowed by the state, plans have the flexibility to provide benefits that are "substantially equal" to the EHB-benchmark but may not always be identical. In addition, the regulations give plans the flexibility to substitute benefits or sets of benefits within an EHB category, unless a state limits or forbids substitution, as long as the substituted benefits are identical in value to the benefits being replaced.

If a plan is proposing to offer coverage that does not include MH and/or SUD coverage, or if that coverage is less than "substantially equal" to the coverage in the benchmark, then the plan should be required to improve its MH/SUD coverage before it can be certified in compliance with the ACA. Similarly, if a plan proposes to weaken the value of the MH/SUD category of coverage by substituting a benefit or set of benefits of lower actuarial value for a benefit or set of benefits of higher actuarial value, its request for certification should not be granted.

The plan's MH/SUD coverage must comply with the ACA's parity requirements

The plan's MH and SUD coverage must be consistent with generally recognized independent standards of current practice

The regulations that implement the federal parity law (MHPAEA) require a plan's MH/SUD coverage to meet standards of clinical practice, such as those established in the DSM-V, the ICD-10, and state guidelines. If the plan's proposed coverage of MH and SUD benefits omits certain levels of care and is inconsistent with generally recognized standards of MH and SUD care, the coverage would violate the MHPAEA requirements of the ACA and would need to be supplemented.

The plan's MH/SUD coverage must be consistent with the parity law's requirement that financial requirements and treatment limitations on MH/SUD benefits not be more restrictive than those imposed on other medical/surgical benefits covered by the plan

The MHPAEA regulations are clear that both quantitative treatment limitations (including day or visit limits or frequency of treatment limits) and non-quantitative treatment limitations (tools plans use to manage their benefits) on MH/SUD benefits must comply with parity. In managing a plan's benefits, and determining which MH/SUD services are covered by the plan and which prescription drugs should be included in the plan's formulary, a plan must ensure that the processes, strategies, evidentiary standards and other factors used to manage their MH/SUD benefits are 1) comparable to and 2) applied no more stringently than the processes, strategies, evidentiary standards and other factors used to manage medical/surgical benefits provided by the plan. While the regulations acknowledge that there may be different clinical standards used in making these determinations about MH/SUD benefits, comparable recognized standards of care must be used and they must not be applied more stringently than those for other medical/surgical benefits in the plan. Under MHPAEA, plans are required to disclose to beneficiaries and plan participants the criteria used to determine medical necessity.

To determine whether a plan meets these parity requirements, regulators should carefully examine the criteria a plan proposes to use to determine whether certain MH/SUD services are covered and whether medications used to assist in the treatment of mental illness or substance use disorders are included on the plan's proposed prescription drug formulary. Regulators should determine whether those criteria are consistent with recognized clinical standards of care and compare the criteria and the way the criteria is imposed with the medical necessity criteria used to make similar coverage decisions about other medical/surgical benefits covered by the plan. Regulators should also look carefully at a plan's financial requirements (co-pays, deductibles, co-insurance, and other out-of-pocket costs) to ensure that they are no more restrictive than the financial requirements for other benefits. If a plan proposes to impose treatment limitations or financial requirements on MH/SUD benefits that are more restrictive than those imposed on other medical/surgical

benefits covered by the plan, then that plan's proposal would not meet the parity requirements of the ACA.

The scope of MH/SUD coverage must be consistent with additional MHPAEA requirements

The federal parity law seeks to ensure that access to MH/SUD care is not more restrictive than for care for other illnesses. The MHPAEA regulations specify that if a plan provides coverage for Outpatient, Inpatient, Emergency Care, and Prescription Drug benefits for the treatment of other illnesses, the plan must also cover MH/SUD services in those benefit categories. Not providing coverage in these benefit categories for MH/SUD, where comparable medical/surgical benefits are covered, would violate parity.

If a plan were to cover medical/surgical benefits that help prevent chronic disease, aid in chronic disease management or provide supports to help people stay healthy, but not cover analogous MH/SUD benefits, that coverage could also be inconsistent with parity and would need to be brought into compliance.

The plan's MH/SUD coverage must comply with the ACA's non-discrimination requirements

The plan's benefits must not be designed and/or managed in a way that discriminates against people with disabilities

The ACA precludes plans from designing and managing the essential health benefits in a way that limits coverage for people with disabilities. The law specifies that the essential health benefits cannot be designed in ways that discriminate against individuals because of their age, disability, or expected length of life. The ACA also prohibits the denial of essential benefits services based on age, life expectancy, disability, degree of medical dependency or quality of life. If a plan is designed or managed in a way that limits coverage for people with disabilities, including individuals with mental illness and SUD, and provides inadequate care, the plan would be in violation of the non-discrimination requirements of the ACA and would need to be brought into compliance with the federal law.

The benefits provided by the plan must address the health care needs of diverse segments of the population

The ACA requires that the essential health benefits address the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. If the benefits offered by the plan exclude certain services or medications that are effective, consistent with recognized standards of clinical care, or are beneficial to diverse groups of people, including individuals with MH and SUD service needs, the benefits may be inconsistent with the ACA and might need to be supplemented to be brought into compliance.

The plan's MH/SUD coverage must comply with the ACA's typical employer coverage requirement

The ACA requires that the scope of coverage in the essential health benefit package be equal to the scope of benefits provided under a typical employer plan. If the plan provides significantly more limited MH/SUD coverage than the MH/SUD coverage generally offered by other employer plans, the ACA's typical employer coverage requirement would not be met.

The plan's MH/SUD benefits category must not be significantly weaker than the other categories

The ACA requires that the essential health benefits reflect an appropriate balance among the ten EHB categories, so that benefits are not unduly weighted toward any category. If the benefits provided in the MH/SUD category are significantly weaker than the other categories, then the plan's MH/SUD benefits would need to be adjusted to bring it into compliance with the requirement that there be balance among the categories.

Part III: Ensuring Qualified Health Plans have Adequate Networks of MH/SUD Providers to Ensure Access to Services without Unreasonable Delay

Background: Health plans requesting or maintaining certification as a qualified health plan for the exchange must maintain a sufficient network of mental health and substance use disorder providers to guarantee enrollees' timely access to the full continuum of MH and SUD services.[2] The regulations governing exchanges require that "a QHP's provider network must maintain a network of a sufficient number and type of providers, *including providers that specialize in mental health and substance abuse*, to assure that all services will be available without unreasonable delay." Below are the Coalition for Whole Health's recommendations for minimum network adequacy requirements for QHP certification and ongoing operations as they relate to access to MH/SUD services. Because network adequacy must be maintained even as plans' provider capacities and enrolled populations change, regulators must review network adequacy at the time a plan requests certification and regularly thereafter as part of ongoing plan management responsibilities. Therefore, this section of the toolkit provides recommendations for both developing standards for certification and conducting ongoing reviews of QHPs.

Messages to state policy-makers: Networks should be sufficient in number, mix, and geographic distribution of providers to ensure access to all covered MH and SUD services in a timely manner that is not detrimental to the health or wellbeing of the enrollee. At a minimum, a qualified health plan should be required to meet network adequacy standards related to:

- Enrollee to provider and staff ratios, including ensuring a sufficient number of MH and SUD providers licensed or certified by the state is available to enrollees to ensure adequate choice, a sufficient number of specialty providers to enrollees, as well as the ratio of enrollees to staff, including health professionals and administrative and other support staff;
- Network sufficiency to ensure enrollees are able to access providers to address their MH and SUD needs within 24 hours for urgent care and ten to fourteen calendar days for routine care, and to ensure that enrollees in need of more comprehensive, coordinated care are able to access providers that offer a full range of services;
- Travel time and distance to providers, which should take into consideration geographical barriers and other barriers, such as a lack of accessibility by public transportation, that are not accounted for by simple mileage and travel time criteria;
- Availability standards, including appointment waiting times, hours of operation, 24 hour service availability when medically necessary, and provider acceptance of new patients. Appointment standards should be followed for transitional care, preventive care, non-urgent care, and emergency care.

[2] Unlike many of the other protections discussed in this toolkit, the network adequacy requirements of the ACA only apply to QHPs. However, state laws may provide important network adequacy requirements for plans operating outside the exchange.

The health plan should be required to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. Distance standards should require reasonable proximity of network providers to enrollees of at least two network MH providers and at least two network SUD providers, for each point along the continuum for these illnesses, within specified urban, suburban, and rural distances for at least 90 percent of plan enrollees. If there are no network providers that meet availability standards, plans should arrange and pay for services provided by a non-network provider at no additional cost to the enrollee.

To ensure that plans meet the minimum standards for network adequacy on a consistent basis, each plan must have in place a system for monitoring its network and develop procedures to react to impending and ongoing changes in its network that may impair adequacy. Plans must demonstrate on an initial and ongoing basis to regulators that they have sufficient capacity to meet the full continuum of MH and SUD needs for the expected enrollment in the service area.

In any case where the health carrier has an insufficient number or type of participating providers to deliver a covered benefit, the health plan should be required to ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

Network adequacy standards should require all plans to undergo a detailed network adequacy review at the time a plan requests certification or expansion, at least annually thereafter, and whenever there are general changes in the plan's provider network. A review should include:

- Anticipated enrollment
- Expected utilization of services
- The numbers and types of providers required to furnish the services
- The total, unduplicated number of MH and SUD service providers in the network
- The numbers of network providers who are not accepting new patients
- The geographic location of providers and plan enrollees, considering distance, travel time, the means of transportation used by enrollees, and physical access for enrollees with disabilities
- The plan's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the MH and SUD needs of its enrolled population
- Identification of any direct or indirect barriers to access

A health plan should also be required to demonstrate that it monitors, on an ongoing basis, the ability, clinical capacity, financial capacity and legal authority of its providers to furnish all contracted benefits to covered persons. The goal of the review is to ensure that the network provides sufficient access to the participating providers in order to deliver the services promised under the benefit contract and consistent with federal and state regulations. If access is not available, then the plan should be required to make

arrangements acceptable to the state insurance commissioner, the state exchange board, federal regulators, or other regulating entities that the services are provided at no greater out-of-pocket cost to the enrollee.

Health plans should also be required to assess and report enrollee satisfaction with their network of MH and SUD providers. These requirements should be applied uniformly to all health carriers offering QHPs on the exchange. This information should be made available to consumers before they enroll in coverage to ensure they make an informed choice.

Plans should be required to submit the provider and intermediary contracts used to create and maintain their MH and SUD networks to the appropriate regulatory authorities for review. Plans should be required to demonstrate to regulators that their contracts with providers:

- Prohibit the plans from using standards to select providers that would allow the plan to avoid providers serving potentially high-risk populations,
- Require plans to make their provider selection standards available for review, and
- Prohibit the plan from penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the plan that jeopardizes patient welfare.

Provider selection standards should be reviewed to ensure that plans are not able to avoid high-risk populations because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health services utilization. Standards should also be reviewed to ensure that a plan cannot exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization. Plans could be required to demonstrate a minimum proportion of overlap between their QHP network and Medicaid managed care networks or providers serving a high number of Medicaid patients in their practices.

There should be a formal enforcement policy in place for plans that do not maintain an adequate network of MH/SUD providers. Depending on the violation, enforcement could include financial penalties, giving a notice and opportunity to correct, restricting the plan's service area if the concern is with a plan's network in a particular area, requiring plans to base an enrollee's responsibility for any coinsurance, deductibles, or copayments related to MH and SUD care on in-network benefits regardless of the provider, precluding a plan from selling new policies, and other formal administrative penalties that may include revocation or suspension of the plan's QHP certification or license.

Working With Your State Insurance Commissioner

A Guide for Substance Use Disorder and Mental Health Stakeholders

Introduction

Your State's insurance commissioner plays an important role in shaping how the Affordable Care Act (ACA) will work "on the ground." Insurance commissioners in most States are involved in:

- Developing and implementing the health insurance marketplace, and
- Monitoring and enforcing compliance with important consumer protections such as guaranteed issue and mandates for mental health and substance use disorder parity.

This Guide offers specific strategies to help you effectively collaborate and communicate with your State's insurance commissioner to raise awareness of health insurance regulatory issues that are most important to people with mental health or substance use disorder service needs.

State Insurance Commissioner Roles and Responsibilities

The State insurance commissioner is the public official responsible for regulating the commercial insurance market in each State. Depending on the State, the insurance commissioner is elected or appointed by the governor. While there are State by State differences, in general insurance commissioners are responsible for the following activities:[1]

- Licensing of insurance companies and agents;
- Regulation of certain insurance products available in a State, including health, auto, home, life, malpractice, etc. to ensure compliance with State insurance laws and to protect consumers;
- Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;
- Providing consumer services such as education, complaint filing and investigation, and fraud reporting;
- Reviewing and monitoring the insurance marketplace to ensure that fair prices are charged for insurance products, that consumers have access to a range of reasonable products, and that insurers are complying with State insurance laws and regulations; and
- Researching and providing technical assistance on insurance issues to State policymakers.

The Affordable Care Act creates new requirements and responsibilities for insurers, many of which will be monitored and enforced by State insurance commissioners. For example, significant premium increases are now subject to review and approval by the State (or Federal government if the State lacks the authority or a system for doing so). In most States, this type of review and approval will fall under the authority of the State insurance commissioner. Keeping health insurance rates reasonably priced is critically important to ensuring that people with substance use and mental health disorders can purchase and/or retain their

[1] National Association of Insurance Commissioners. (2011). *State insurance regulation*, http://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf

health insurance. In another example, beginning in 2014 insurers will no longer be allowed to deny persons coverage for having a pre-existing condition, such as a substance use disorder. This is sometimes referred to as "guaranteed issue."

Parity for substance use and mental health treatment is another area where the State insurance commissioner plays an important role in ensuring that insurance products comply with State and Federal laws. For example, the State insurance commissioner is responsible for enforcement of the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the "parity" law that requires group health insurance plans with 50 or more employees that offer mental health and/or substance use disorder benefits to provide them in a way that is no more restrictive than the plan's physical health benefits. The ACA built on the Federal parity law to extend the requirements of the MHPAEA to the individual and small group insurance markets beginning in 2014, which will also fall under the purview of the insurance commissioner.[2]

It is important to understand that MHPAEA does not pre-empt State parity laws that provide stronger consumer protections, including those which may require coverage of mental health and substance use disorders. Learning about parity and other State mandates related to the coverage of mental health and substance use disorders will help arm you with the information necessary to effectively communicate with your State's insurance commissioner. Please see the resources section for links on how you can find out if your State has specific parity requirements in addition to the Federal requirements.

Understanding what the insurance commissioner does not have authority over is just as important as knowing what they do have purview over, so that you know which issues are appropriate to bring to the insurance commissioner (or not). The insurance commissioner does not make laws, such as those requiring coverage for certain diagnoses or particular treatments or providers, but rather monitors compliance and enforces laws made by legislative bodies. In contrast, the authority to mandate coverage for a certain type of care provider (e.g. substance use counselors) or treatment (e.g. Applied Behavioral Analysis) may fall under the purview of the State legislature, State commissioner for mental health and/or substance use, or State Medicaid Director (specific to Medicaid coverage), depending on the State.

Certain types of health insurance programs or products do not fall within the purview of a State's insurance commissioner. For example, the Medicare and Medicaid programs, Veteran's Administration benefits, and self-insured health plans[3] are not regulated by a State's insurance commission. Enforcement of certain Federal laws such as the Health Insurance Portability and Accountable Act (HIPAA) privacy rule, which addresses the use and disclosure of protected health information, and the Consolidated Omnibus Budget Reconciliation Act (COBRA) which gives workers and their families who lose their health benefits the right to elect to continue coverage, are regulated by the Department of Health and Human Services Office for Civil Rights and the Department of Labor/Internal Revenue Service, respectively. However, your State insurance commissioner may have roles in enforcing HIPAA protections and additional protections around privacy or retaining coverage.

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[2] MHPAEA does not require that insurers cover substance use and mental health benefits, but says that if large group plans cover these benefits, then they must do so at parity with the medical/surgical benefits covered by the plan. The ACA, however, requires small group and individual market plans to cover substance use and mental health benefits as part of the essential health benefits package, and requires that those benefits be provided at parity.

[3] Self-insured health plans are typically offered by large employers or trade unions and differ from fully-insured plans in that the plan sponsor (the employer or union) is at risk for medical claims made by its covered employees or members. Most self-insured health plans are regulated by the United States Department of Labor, Employee Benefits Security Administration (DOL-EBSA) under the Federal Employment Retirement Income Security Act (ERISA). However, DOL-EBSA does not regulate self-insured plans that are sponsored through school districts, municipalities, and churches.

Strategies for Collaborating with the Insurance Commissioner

Learn About the Insurance Commission/Department In Your State

Before approaching the State insurance commission with an issue or concern, spend some time learning about the insurance commission and the relevant laws or mandates specific to health insurance in your State. Find out who the insurance commissioner is, their role in regulating health insurance, what the structure and function of the various offices within the insurance commission are, and what authority they do or do not have related to the particular issue(s) that are important to you. Each State is different with respect to insurance laws and mandates and the authority and purview of the State insurance commission; do not assume what is required in one State will be the case in your State.

Inform the Insurance Commission About You/Your Role/Your Organization

As noted above, the insurance commissioner has oversight and responsibility for more than just health insurance products, so his/her knowledge or awareness of needs and issues specific to people with mental health and substance use disorders is most likely limited. Do not presume they know the mental health or substance use field or who you or your organization is. Be prepared to briefly describe who you are and who you represent. Having a one page overview available to share that describes who you and/or your organization are will help educate him/her about some basic facts about your organization and the policy issues you care about.

Power of Coalition

Joining with others who share your perspective can bring additional resources and attention to your issue(s). Representatives from the business community, provider organizations, general health care advocacy organizations, or stakeholders from other constituency groups (e.g. people with physical or developmental disabilities, traumatic brain injuries, etc.) can be particularly powerful and assist in getting your issue heard. They may also have valuable experience working with your commissioner already.

Develop and Maintain Opportunities for Ongoing Dialogue

Try to schedule a regular standing meeting with the insurance commissioner and/or relevant staff from their office. A predictable forum where issues can be discussed will allow both parties the opportunity to maintain a regular dialogue. It will also help keep you and your organization's issues "on the radar screen" of the insurance commissioner. It is much harder to let things fall through the cracks if he/she knows the issue will be a topic at your next meeting.

Prior to these meetings, consider creating an agenda and sending it to the person(s) you are meeting with so they can come prepared to discuss the relevant issues, and invite them to add any items of importance to the agenda in advance of the meeting as well. This allows for a more productive meeting for both sides, where no one is left feeling ambushed or "put on the spot".

It is also important to identify two or three goals or priority issues that you want to focus on with the insurance commissioner. Approaching him/her with a laundry list of problems can distract both sides from accomplishing anything leading to feelings of frustration for everyone involved.

Provide a Concise Analysis and Proposal

In advance of approaching the insurance commissioner with a specific issue(s) or concern(s), do your homework. Conduct a thorough analysis of the issue(s) at hand and bring something in writing to leave behind. This analysis may include:

- A brief description of the issue or concern. Quantitative data that details the scope of the problem will be particularly important to include if available.
- Information about its impact on the people/population in question. This might include an anecdote or two that are representative of how the issue has affected you or your constituency.
- A discussion of what will happen if the issue is not addressed.

Including a menu of strategies for remedying the issue(s) will lend your analysis weight as well. Be prepared to address how your proposal will not only affect the population you care about but other groups as well. Including details about how it might affect insurance companies and/or the businesses that supply or purchase insurance will help you to be prepared for all sides of the issue.

Highlight in your discussion the existence of any current service, program, or policy that addresses the problem in a way that may be relevant for your State. Examples from other States are particular helpful. Data such as costs or the number of people impacted will be particularly important to include if available.

Be Realistic About Your Expectations

State government can be complex and slow moving. It is also true that many State governments are under-resourced, particularly in this economic climate. Things might move more quickly if you can offer assistance or support in some way. Can you/your organization help do research, develop partnerships, conduct outreach or awareness activities, or collect data? Offering to partner with them may help you accomplish your objectives more quickly and make the task seem less daunting and more manageable for the commissioner and his/her staff.

Summary

Your State's insurance commissioner can be an important ally in helping make sure that people with substance use disorders and mental illness can access the benefits they need to help them in their recovery process. Developing effective communication and collaboration skills can help you to develop a successful partnership with your insurance commissioner.

For More Information

The website of the **National Association of Insurance Commissioners (NAIC)** includes an interactive map with links to the insurance department for each State, consumer guides, a glossary of relevant insurance terms, and information about ACA implementation activities: http://www.naic.org/

The **Consumer Information Source (CIS)** allows you to locate important information about insurance companies, including closed insurance complaints, licensing information and key financial data. It also allows you to file a complaint about an insurance company, broker, or agent, or report suspected fraud directly with your State insurance department: https://eapps.naic.org/cis/index.do

The **Kaiser State Health Facts** website includes links to State specific facts on health insurance, managed care, and other health information: http://Statehealthfacts.org/

Information about the Paul Wellstone and Pete Domenici **Mental Health Parity and Addiction Equity Act** can be located at: http://www.samhsa.gov/healthreform/parity/ and http://parityispersonal.org/ which also includes links to State parity laws.